

Application for Assistance

Health Coverage

Child Care

Food Stamps

Telephone Assistance

Nursing Home Care

Cash Assistance

Available in Spanish. We provide interpreter services at no cost.

Disponible en español.

Proveemos servicios de interprete sin costo a usted.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

For application help,
contact this local H&W Office:

or

2-1-1 CareLine
Idaho
dial **2-1-1** or
1-800-926-2588
TDD 208-332-7205

Appointment Date: _____
Appointment Time: _____

Instructions

To apply for benefits, follow these easy steps:

1. Complete the Application

Complete the three pages of the application. Please be accurate. If you are applying for someone else, answer the questions as they relate to that person.

2. Submit the Application

Once you have completed the application, mail it or bring it to the Health and Welfare office nearest you. The date your assistance will start is based on the date the application is received by the Health and Welfare office, so do not delay. If you are applying for Food Stamps only, you can initiate your application with just your name, address and signature.

3. Provide Any Needed Proof

Look at the table below to see what proof is required for the programs you are applying for. Including copies of the requested proof will help speed the processing of your application.

4. An Interview May Be Required

An interview is not required for health coverage or child care. For Food Stamps, cash assistance, and other programs, an interview may be required before a decision about your benefits can be made. Please contact your local office if you can't participate in an interview during our normal office hours.

Do I Have to Be a Citizen?

No. Please do not let fear of the Immigration and Naturalization Service (INS) keep you from seeking needed benefits for your family. Receiving health coverage, Food Stamps, and child care for your eligible children will not prevent you from gaining lawful, permanent residence or U.S. citizenship, or from sponsoring relatives, if you can support them.

Don't Delay

If you are applying for Food Stamps only, to begin the application process immediately, you only need to give us your name, address and signature.

Equal Opportunity

This application will be considered without regard to race, color, gender, age, disability, religion, national origin, or political belief.

Questions?

If you have any questions about applying, contact your local Health and Welfare office or call 1-800-926-2588. This application also is available on the Internet at www2.state.id.us/dhw and www.idahochild.org.

All applicants for Temporary Assistance for Families in Idaho (TAFI) will be asked to participate in a substance abuse assessment.

Needed Proof by Program

In addition to your application, please provide any proof required for program (s) you are applying for.

	HEALTH COVERAGE for families and children	CHILD CARE**	FOOD STAMPS***	CASH ASSISTANCE	HEALTH COVERAGE for elderly and disabled
Proof you have applied for a Social Security Number (if you don't already have one)	✓		✓	✓	✓
Resident Alien Card (if not a U.S. citizen) or other residency documents	✓		✓	✓	✓
Proof of any other health insurance	✓				✓
Proof of income* or any other money coming into your household		✓	✓	✓	✓
Most recent statements for any bank accounts (checking, credit union, savings, etc.)			✓	✓	✓
Value of car/truck or other vehicles such as motorcycles, boats, RVs			✓	✓	✓
Proof of current value of stocks/bonds, certificates of deposit, life insurance, trusts			✓	✓	✓
Proof of identity			✓		
Proof of any child care costs (if applicable)		✓	✓	✓	
Immunization records for any children not yet in school (if applicable)		✓		✓	

* For example, wage stubs from the last 30 days if you are employed, or federal income tax records if you are self-employed.

** Your child care amount may increase if you provide proof of child support paid for children not living with you.

*** Your Food Stamp amount may increase if you also provide proof of these expenses: child care costs; child support paid for children not living with you; housing costs; utility costs; medical expenses (including prescriptions) for people with disabilities or who are over 60.

Case #: _____

☐ Received by Mail

Assigned to: _____

Date Received: _____

Application for Assistance

IMPORTANT NOTICE: If you need any of the following help, please ask. These services are free:

- Language interpreter: Nosotros proveemos los servicios de un intérprete, sin costo alguno).
Call (telefono) Idaho CareLine, 2-1-1 o 1-800-926-2588 o TDD 208-332-7205;
- Help filling out this form;
- Form in another format (Braille, large print, reader for the blind); or
- Accommodation for a disability.

Your First Name	Middle Initial	Last Name	Former Names, if any
Home Address	City	County	State
Mailing Address (if different)	City	County	State
Daytime Phone Number	If none, when can we reach you? Phone:		E-Mail Address

I would like to receive:

- ☐ Health Coverage (CHIP or Medicaid)
 ☐ Food Stamps
 ☐ Child Care Costs
 ☐ Telephone Assistance
☐ Nursing Home/In-Home Care: _____ (Nursing Home Name)
 ☐ Cash Assistance
☐ Other Services _____


Skip this section unless you are applying for Food Stamps.

Are any members of your household migrant or seasonal farm workers?

☐ Yes ☐ No

Is your income this month less than \$150?

☐ Yes ☐ No

Are your resources (cash, checking, savings) less than \$100?

☐ Yes ☐ No

If you need Food Stamps right away, benefits can begin within seven days.

To make sure you receive all the help you qualify for, answer the following questions by checking yes or no and listing who:

			Who?
Does anyone in your household have a disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Is anyone in your household applying for or receiving Social Security?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do any children in your home have a parent not living with them? *	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Has anyone been convicted of a felony involving drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
If yes, who was convicted, and what year was the felony conviction? _____			

(If yes, you will be asked to give information about that parent to Child Support Services. You are required to provide this information to receive most benefits unless you fear harm to yourself or your children. **However, you are not required to provide this information to apply only for medical coverage for your child.*

PERSONAL/AUTHORIZED REPRESENTATIVE: You may authorize someone else to apply for benefits for you and to use your Food Stamp benefits to buy food for you. If you want to name authorize someone, enter his/her name, phone and address below:

Name: _____ Phone Number: _____

Address: _____

NOTE: If your authorized representative gives us incorrect information that causes us to give you benefits you are not entitled to receive, you will have to repay the extra benefits to us.

Source Code



Please list each person who lives in your home. Complete the information on this side of the line for each one. Include unborn children and due date.

Answer the questions on this side only for people requesting benefits. Any Social Security or immigration information on this application is private and will be used only for deciding eligibility.

NAME (First, Middle, Last)	RELATION (spouse, child, stepchild)	DATE OF BIRTH	SEX	PREGNANT? (✓ if yes)	OTHER HEALTH INSURANCE? (✓ if yes)	APPLYING FOR? (✓ all that apply)	PLEASE COMPLETE THE APPROPRIATE INFORMATION
	Self		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health Coverage <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other	Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # _____
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health Coverage <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other	Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # _____
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health Coverage <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other	Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # _____
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health Coverage <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other	Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # _____
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health Coverage <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other	Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # _____
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health Coverage <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other	Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # _____
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Health Coverage <input type="checkbox"/> Food Stamps <input type="checkbox"/> Other	Social Security # _____ U.S. Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No Alien ID # _____

Household Income: List money received and/or expected for this month. Include wages, self-employment, odd jobs, unemployment benefits, disability payments, Social Security, loans, gifts, and money children received, etc. Include adoption assistance or foster care payments you receive for any child in your home. We need your **GROSS** income (income before deductions) and your **NET** income (the amount you take home).

Name of Person with Income (If wages, list employer name)	Source (Wages, Unemployment, etc.)	What Kind of Income (Wages, Unemployment, etc.)	Gross Amount (Before Taxes)	Net Amount (After Taxes)	How Often Paid (Weekly, Monthly, etc.)	Pay Rate (\$ Per Hour)	Hours Worked Per Week

Has anyone in your household sold, transferred, or given away any cash, property, or other assets — things you own — in the past 36 months?

Who	Date	What Assets

Ethnicity and Race Information

Completion of this section of the Application for Assistance (AFA) is voluntary. Your selection of race and ethnicity will not affect your eligibility for benefits or your benefit amounts. This information is being collected to assure that program benefits are distributed without regard to race, color, or national origin. For the purposes of this section, "Hispanic or Latino" is considered an ethnicity, not a race. **Please answer both ethnicity and race questions for each person.**

Name (First, Middle, Last)	Ethnicity (✓ option that best describes each person)	Race (✓ one or more options that best describe each person)	Ethnicity and Race Definitions
	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	Ethnicity Definition Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. Race Categories Definitions American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam Black or African American A person having origins in any of the black racial groups of Africa. Native Hawaiian or Pacific Islander A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	White A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	
	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	
	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	
	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White	

Please tell us the following information:

1. Does anyone applying for health coverage need help paying medical bills from the last three months? ☐Yes ☐No
If yes, who? _____. List all income or money received by your family in the last three months.

Last Month

Two Months Ago

Three Months Ago

2. As of today, how much does your household/family (including children) have in:

Cash

Checking

Savings

Other Accounts/Trusts

3. List the year, make, model, and value of each car, truck or motorcycle your household owns. List others on back.

Year/Make/Model/Value/Amount You Owe

Year/Make/Model/Value/Amount You Owe

4. What is the **total value** of other assets such as land, trailers, boats, snowmobiles, other recreational vehicles?
(Do not include the home where you live.) \$ _____

5. List monthly amount paid for dependents or **child care** to someone not living in the home. \$ _____

6. List monthly **child support** amount paid to someone not living in the home. \$ _____



Skip questions 7-9 unless you are applying for Food Stamps. List total monthly amounts of any of the following expenses that any member of your household pays or owes. Your Food Stamp amount may increase if you provide proof of these expenses.

7. **Housing costs** (mortgage/rent, homeowner's insurance, taxes, irrigation, space rent, etc.) \$ _____

8. **Utility costs** (do not include past due amounts) \$ _____

9. **Medical expenses** (include Medicare and/or health insurance premiums, doctor, dental, prescription, eye glasses, hospital costs, etc.) \$ _____

I understand that . . .

- **Knowingly providing false information or withholding information may result in criminal, civil or administrative action (including denial of benefits or required repayment of benefits).**
- **My signature (or the signature of my representative) authorizes State and federal officials to get and use computerized and other information about me to determine if I am eligible for benefits.**
- **I may request a fair hearing if I disagree with decisions made regarding this application, and I have 30 days (90 days for Food Stamps) to do so.**
- **I must turn over any medical reimbursement payments I receive while I am enrolled in State health coverage to the Department of Health and Welfare.**
- **By applying for benefits — other than medical benefits for your child — a child support case must be opened, when applicable.**
- **My signature below certifies that the citizenship/immigration status marked on page 2 is correct for each person applying.**

I, _____, swear that the information given on this form is true and correct.

Signature of Applicant/Authorized Representative

Date